

Franziska K. Dutton, D.D.S.

Daniel Cohen D.D.S.

Financial Policy

Our fees are based on the quality of the products and materials we use and our experience in performing your scheduled treatment.

Our goal is not to let expense prevent you from benefiting from the quality of care you desire and need. We also realize that every patient's financial situation is different. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

- Payment is due at the time of service.
- If you use **CARE CREDIT or CHERRY FINANCING** to pay your bill there will be a **7% fee** added to the total.
- We gladly accept Visa, Mastercard, Discover and American Express.
- We offer a 5% discount for all patients without insurance who pay with cash or check.
- **For patients with insurance:** We are an **OUT OF NETWORK PROVIDER WITH ALL INSURANCE COMPANIES**. We will do our very best to give you the most accurate estimate we can, however **any balance that the insurance does not pay for ANY reason is the patient's responsibility**.
- The entire estimated patient portion is due at the time of service. **We expect you to know your own insurance benefits and amounts used/remaining**, however we are happy to help answer any questions we can.
- Past due balances are subject to a 2% finance charge.
- Any returned check will be charged a \$35.00 fee.

Appointment Cancellation Policy

In order to be respectful to the needs of other patients, please arrive on time for your appointment. Please call promptly if any unforeseen circumstance occurs. **WE REQUIRE A 48 HOUR NOTICE.**

Please initial each of the following statements:

_____ If 48 hour notice is not given or an appointment is missed, a \$25 charge per half hour of scheduled time with a hygienist and \$50 per half hour of time scheduled with either of our doctors. This charge will be due prior to rescheduling your next appointment.

_____ Once an appointment is missed or rescheduled without the required 48 hour notice, we will require a deposit in order to reserve you another appointment with our doctors and their assistants.

Patient Signature: _____ Date: _____

*A holder of this medical debit contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debit to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debit to a consumer credit reporting agency the debt shall be void and unenforceable.